Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL EQUIPMENT DEVICE SPECIALISTS
7950 DUNBROOK RD
SAN DIEGO CA 92126

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number: 01

MFDR Tracking Number

M4-11-4143-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty Mutual has failed to respond as to why every patient falls under xe20, and failed to identify which of the three denial reasons was the applicable one for each respective patient that was denied."

Amount in Dispute: $3,017.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DME charges in dispute were denied because they are outside of the ODG and the required preauthorization was not requested. Rule 137.100(d) relates to a carrier's responsibility for reimbursement of treatments or services outside the ODG."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2009 through July 10, 2010	DME Equipment and Supplies	$ 2,403.76	$0.00
July 17, 2010, August 10, 2010, September 10, 2010, October 10, 2010,	DME Equipment – HCPCS Code E0731 DME Supplies – HCPCS Code A4595	$613.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting an Independent Review Organization (IRO).
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 17, 2010; August 18, 2010; October 5, 2010; September 7, 2010:
   - XE20 – These services were delivered for a non-authorized DME device. The DME provider failed to obtain pre-authorization or the DME device was deemed in appropriate for the work related injury, by extension all related supplies lack the requisite authorization as well and are not separately reimbursement.
   - B15 – Payment adjusted because this service/procedure is not paid separately.
   - X435 – Based on Peer Review, further treatment is not recommended.
   - W9 – Unnecessary medical treatment based on a Peer Review.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed a dispute with Medical Fee Dispute Resolution section at the Division on July 14, 2010. This dispute contained dates of service that were not submitted in accordance with 28 Texas Administrative Code §133.307(c)(1)(A). The dates of service that were not submitted timely are October 5, 2009 through July 10, 2010. These dates of service are not eligible for review by Medical Fee Dispute Resolution.
2. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of medical necessity have been resolved as of the undersigned date.
3. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 5, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.